APPEAL NO. 010258

This appeal arises pursuant to the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq.* (1989 Act). A contested case hearing (CCH) was held on January 9, 2001. With regard to the only issue before him, the hearing officer determined that the respondent (claimant) had an 18% impairment rating (IR) as assessed by the treating doctor and that the great weight of the other medical evidence was contrary to the 14% IR assessed by the designated doctor.

The appellant (carrier) appealed, contending that the designated doctor's report has presumptive weight and that the claimant did not have a ratable loss of function entitling the claimant to a motor or sensory deficit rating. The claimant responds (in a response co-signed by the treating doctor), urging affirmance.

DECISION

Affirmed.

The claimant sustained a compensable low back lifting injury on _____. The carrier's required medical examination doctor, Dr. W, in a report dated July 23, 1999, certified maximum medical improvement (MMI) (MMI is not at issue) and assessed a 5% IR based on Table 49, Section (II) (B) of the Guides to the Evaluation of Permanent Impairment, third edition, second printing, dated February 1989, published by the American Medical Association (AMA Guides). Dr. W invalidated range of motion (ROM) and did not assess an impairment for motor or sensory deficits. This rating was apparently disputed and Dr. C was appointed as the designated doctor. (Both the designated and treating doctor are chiropractors, while Dr. W is an M.D.).

Dr. C, in a report dated October 30, 1999, certified MMI and assessed a 14% IR based on a 7% impairment for a specific disorder from Table 49, Section (II) (C) and 8% impairment for loss of ROM. Both the treating doctor and Dr. C agree on the specific disorder and ROM portions of the IR. Although Dr. C mentions sensory deficit and defines it as "loss of sensation associated with peripheral nerve damage and accompanied by pain," she does not assess any impairment for motor or sensory deficit.

Dr. O, the treating doctor, in reports dated November and December 1999, assessed an 18% IR. Dr. O agreed with Dr. C on the 14% impairment for the specific disorder and loss of ROM but also found nerve disorders resulting in an 8% impairment of the right leg and 5% impairment of the left leg (which translates to a 3% and 2% whole person impairment), which is combined in the Combined Values Chart of the AMA Guides to arrive at the 18% IR. Dr. O stated that he agreed with Dr. C on the ROM and specific spinal disorder but that Dr. C

> did not give the patient a rating for neurological impairment which the patient is entitled to. It appears that [Dr. C] omitted the sensory rating that is

> outlined in Table 10 on page 40 [of the AMA Guides]. The patient is entitled to impairment based upon nerve conduction/DSEP/SSEP studies that were performed by [Dr. B] on June 10, 1998.

Dr. O's report and comments were sent to Dr. C, who replied by letter dated June 7, 2000, stating:

> It has always been my policy that when I rate ROM and specific disorders, I do not grant additional impairment for sensory loss as I feel that is double rating. The specific disorders specifically addresses IVD or other soft tissue injury including herniated nucleus pulposus. It has always been my position that the additional impairment value added solely for this purpose takes into account the associated symptoms from the soft tissue injury and disc herniation, including impingement of the nerve roots or cord which would cause sensory loss.

Dr. O testified at the CCH and referenced a note on page 66 of the AMA Guides (beneath Figure 79). That note provides that "if an impairment results strictly from a peripheral nerve lesion, the evaluator *should not* apply the impairment values . . . . However, when restricted motion or ankylosis exists but cannot be attributed to sensory involvement or weakness, then values from Sections 3.2a through 3.2d may be combined with values of this section. [Emphasis in original.]" Dr. O testified that the loss of ROM cannot be attributed to the sensory loss, therefore, it should be rated and that Dr. B in EMG and NCV studies found bilateral L5 radiculopathy.

The hearing officer accepted Dr. O's testimony and found that Dr. O's reports constituted the great weight of other medical evidence contrary to the designated doctor's report. Both sides referenced Texas Workers' Compensation Commission Appeal No. 93756 (the claimant incorrectly refers to it as 93765) decided October 6, 1993. That case held only "that radiculopathy must result in loss of function in order to translate into an [IR]." The carrier argues that there was no loss of function; however, it is not clear whether Dr. C and Dr. O found a loss of function. (Dr. O only comments on bilateral radiculopathy as found by Dr. B.)

The hearing officer commented that Appeals Panels "have held that a doctor giving an [IR] must rate for specific disorders, [ROM], and neurological deficits. Neurological deficits include motor loss and sensory loss. [Dr. C] did not rate the Claimant for her motor or sensory losses. [Dr. O] did rate the Claimant for her motor and sensory losses."

The hearing officer did not err in his interpretation of the AMA Guides and Appeals Panel decisions. Accordingly, we affirm the hearing officer's decision and order.

Thomas A. Knapp
Appeals Judge

CONCUR:

Judy L. S. Barnes
Appeals Judge

Robert W. Potts
Appeals Judge